

EXHIBIT D

| | | |
|---------------------------|---------------------------------------|-------------------------------|
| Covington County Sheriff | MEDICAL SCREENING FORM | Booking Number 200007743 |
| Printed: Tue May 03, 2005 | AL EVERITT BOYETT (S416081511) | Booking Date MAY 3rd, 2005 |

ADMISSION OBSERVATIONS

| | | | | | |
|---|--|--|--|---|--|
| Is inmate conscious? | <input checked="" type="radio"/> Y <input type="radio"/> N | Is inmate capable of responding? | <input checked="" type="radio"/> Y <input type="radio"/> N | Can inmate walk on own? | <input checked="" type="radio"/> Y <input type="radio"/> N |
| Any difficulty breathing? | Y <input checked="" type="radio"/> N | Is inmate hostile/aggressive? | Y <input checked="" type="radio"/> N | Any visible signs of trauma, bleeding, wounds or illness? | Y <input checked="" type="radio"/> N |
| Did arrest result in injury? | Y <input checked="" type="radio"/> N | Any fever, swollen lymph nodes, or jaundice? | Y <input checked="" type="radio"/> N | Is skin in good condition and free of vermin? | Y <input checked="" type="radio"/> N |
| Is inmate under obvious influence of alcohol? | <input checked="" type="radio"/> Y <input type="radio"/> N | Is inmate under obvious influence of drugs? | Y <input type="radio"/> N | Any visible signs of alcohol or drug withdrawal symptoms? | Y <input checked="" type="radio"/> N |
| Does inmate suggest risk of suicide? | Y <input checked="" type="radio"/> N | Do you consider inmate an escape risk? | Y <input checked="" type="radio"/> N | | |

Observations

WOULD NOT ANSWER QUESTION ON INFLUENCE OF DRUGS

INMATE QUESTIONNAIRE

HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS?

| | | | | | |
|------------------------------|--|--------------------------|--|-------------------------|--|
| Hepatitis | <input checked="" type="radio"/> Y <input type="radio"/> N | Heart Disease | Y <input checked="" type="radio"/> N | Mental/Emotional Upset | <input checked="" type="radio"/> Y <input type="radio"/> N |
| Tuberculosis | Y <input checked="" type="radio"/> N | Hypertension | Y <input checked="" type="radio"/> N | Attempted Suicide | Y <input checked="" type="radio"/> N |
| Sexually Transmitted Disease | Y <input checked="" type="radio"/> N | Epilepsy/Convulsions | Y <input checked="" type="radio"/> N | Asthma/Emphysema | Y <input checked="" type="radio"/> N |
| Ulcers | Y <input checked="" type="radio"/> N | Hemophiliac (bleeder) | <input checked="" type="radio"/> Y <input type="radio"/> N | Cancer | Y <input checked="" type="radio"/> N |
| Kidney Trouble | Y <input checked="" type="radio"/> N | Aids/Exposed to Aids | Y <input checked="" type="radio"/> N | Diabetes | Y <input checked="" type="radio"/> N |
| DT's | Y <input checked="" type="radio"/> N | Skin Problems | Y <input checked="" type="radio"/> N | Use Insulin | Y <input checked="" type="radio"/> N |
| Drug Addiction | Y <input checked="" type="radio"/> N | Alcoholism | Y <input checked="" type="radio"/> N | Mental Illness | Y <input checked="" type="radio"/> N |
| Recent Head Injury | Y <input checked="" type="radio"/> N | Coughed/Passed Blood | Y <input checked="" type="radio"/> N | Recent Hospital Patient | Y <input checked="" type="radio"/> N |
| Recent Treatment | Y <input checked="" type="radio"/> N | Use Needles | <input checked="" type="radio"/> Y <input type="radio"/> N | False Limbs/Teeth | Y <input checked="" type="radio"/> N |
| Contagious Disease | Y <input checked="" type="radio"/> N | Pregnant/Recent Delivery | Y <input checked="" type="radio"/> N | | |

Doctors Name and Address

NO

Health Insurance

NO

Special Diet

Doctors Name and Address

Medications

Drug, Allergies

NO

Prescriptions

I have read the above carefully and have answered all questions

Inmate's Signature

Officers's Signature

C. J. 1006 BLUE

MEDICAL STAFF REVIEWING SCREENING FORM

Southern Health Partners

| | | | | | |
|------------------------------|---------------------------|---|---|----------------------------------|---------------------|
| LAST NAME <u>Smith</u> | FIRST NAME <u>John</u> | MIDDLE <u>W</u> | INTAKE DATE <u>5/16/05</u> | SCREENING DATE <u>5/16/05</u> | TIME <u>1:15</u> |
| PREVIOUS INCARCERATIONS | SEX <u>M</u> | SOCIAL SECURITY NO. <u>416-12-1011</u> | DOB <u>1-12-41</u> | | |
| CURRENT INSURANCE COVERAGES? | | | CURRENTLY UNDER PHYSICIAN'S CARE FOR CHRONIC CONDITION? | | |

VISUAL / MEDICAL OBSERVATION: (Explain all "Yes" Answers) Circle Y or N:

| | |
|---|----------|
| Is inmate unconscious or showing visible signs of illness, injury, bleeding, pain, or other symptoms suggesting the need for immediate emergency medical referral? If yes: | YES Y |
| Are there any visible signs of fever, jaundice, skin lesions, rash, or infection: cuts, bruises, or minor injuries; needle marks, body vermin? If yes: | Y |
| Does the inmate exhibit any signs that suggest the risk of suicide, assault, or abnormal behavior? If yes: | Y |
| Does the inmate appear to be under the influence of, or withdrawing from drugs or alcohol? If yes: | Y |
| Is the inmate's mobility restricted in any way due to deformity, cast, injury, etc. If yes: | Y |

ASK THE INMATE THESE QUESTIONS: (Explain all "Yes" answers)

| | |
|--|---|
| Have you had or been treated for: (circle as appropriate) asthma, diabetes, epilepsy, heart condition, high blood pressure, mental health problems, seizures, ulcers, or other conditions? Other: | Y |
| Have you taken or are you taking any medication(s) prescribed for you by a physician? If yes: | Y |
| Are you allergic to any medications, foods, plants, etc.? <u>Penicillin</u> If yes: | Y |
| Have you fainted or had a head injury within the last 72 hours? If yes: | Y |
| Do you have or have you been exposed to AIDS, hepatitis, TB, VD, or other communicable disease? If yes: <u>(HIV) - AIDS + Syphilis (other) last yr</u> | Y |
| Have you been hospitalized by a physician or psychiatrist within the last year? If yes: | Y |
| Have you ever considered or attempted suicide? If yes: | Y |
| Do you have a painful dental condition? <u>Dental abscess</u> If yes: | Y |
| Are you on a specific diet prescribed by a physician? If yes: | Y |
| Do you use drugs? How often? <u>all 7 days</u> Last time? <u>all 7 days</u> What kind? <u>all 7 days</u> How much? <u>all 7 days</u> | Y |
| Do you use alcohol? How often? <u>all 7 days</u> Last time? <u>all 7 days</u> What kind? <u>all 7 days</u> How much? <u>all 7 days</u> | Y |
| Females: LMP Date: Are you pregnant, recently delivered or aborted; on birth control pills; having abdominal pain or discharge? If yes: <u>N/A</u> | Y |

NOTE VITAL SIGNS:

| | | | |
|------------------------|------------------|--------------------------|-------------------------------|
| Respiration: <u>18</u> | Pulse: <u>78</u> | Temperature: <u>97.7</u> | Blood Pressure: <u>133/78</u> |
|------------------------|------------------|--------------------------|-------------------------------|

HAVE ALL CONCERNS FROM OFFICER INTAKE FORM BEEN ADDRESSED WITH INMATE? YesARE ALL STATED CHRONIC CONDITIONS NOTED? YesPPD IMPLANTED? Y OR N ARM LOCATION: R OR L IS H&P SCHEDULED FOR 14 DAYS? Yes

REMARKS:

I have answered all questions truthfully. I have been told and shown how to obtain medical services and advised on how to obtain medication up hereby give my consent for professional services to be provided to me by and through Southern Health Partners, Inc.

Inmate's Signature: John W. Smith Date: 5/16/05Interviewer's Signature and Title: John W. Smith Date: 5/16/05

1955

Ms. (Bibl. 22)

10/10/1961

[Faint handwritten notes at the bottom of the page]

M. ... → R. R. R. R.

MC → ~~1000000~~ 3000

An

$\rho_m \rightarrow \text{ср } R/R \cap \omega_R$

Don't 6-29-03
M. J. J. J. J. J.

100-443886-100

1955

11/11/11

SEARCHED FOR

11/18

416-08-1511

44-08-1511

| | | | |
|---------------------------|---------------------------------------|--|---------------------------------------|
| Covington County Sheriff | MEDICAL SCREENING FORM | | Booking Number 200008027 |
| Printed: Wed Jun 08, 2005 | AL EVERITT BOYETT (S416081511) | | Booking Date JUNE 7th, 2005 |

| ADMISSION OBSERVATIONS | | | |
|--|--|--|--|
| Is inmate conscious? | <input checked="" type="radio"/> Y <input type="radio"/> N | Is inmate capable of responding? | <input checked="" type="radio"/> Y <input type="radio"/> N |
| Any difficulty breathing? | Y <input checked="" type="radio"/> N | Is inmate hostile/aggressive? | Y <input checked="" type="radio"/> N |
| Did arrest result in injury? | Y <input checked="" type="radio"/> N | Any fever, swollen lymph nodes, or jaundice? | Y <input checked="" type="radio"/> N |
| Is inmate under obvious influence of alcohol? | Y <input checked="" type="radio"/> N | Is inmate under obvious influence of drugs? | Y <input checked="" type="radio"/> N |
| Does inmate suggest risk of suicide? | Y <input checked="" type="radio"/> N | Do you consider inmate an escape risk? | Y <input checked="" type="radio"/> N |
| Observations INMATE APPEARS FINE AT TIME OF INTAKE | | | |

| INMATE QUESTIONNAIRE | | | |
|--|--|--------------------------|--------------------------------------|
| HAVE YOU EVER HAD/HAVE ANY OF THE FOLLOWING ILLNESSES OR CONDITIONS? | | | |
| Hepatitis | <input checked="" type="radio"/> Y <input type="radio"/> N | Heart Disease | Y <input checked="" type="radio"/> N |
| Tuberculosis | Y <input checked="" type="radio"/> N | Hypertension | Y <input checked="" type="radio"/> N |
| Sexually Transmitted Disease | Y <input checked="" type="radio"/> N | Epilepsy/Convulsions | Y <input checked="" type="radio"/> N |
| Ulcers | Y <input checked="" type="radio"/> N | Hemophiliac (bleeder) | Y <input checked="" type="radio"/> N |
| Kidney Trouble | Y <input checked="" type="radio"/> N | Aids/Exposed to Aids | Y <input checked="" type="radio"/> N |
| DT's | Y <input checked="" type="radio"/> N | Skin Problems | Y <input checked="" type="radio"/> N |
| Drug Addiction | Y <input checked="" type="radio"/> N | Alcoholism | Y <input checked="" type="radio"/> N |
| Recent Head Injury | Y <input checked="" type="radio"/> N | Coughed/Passed Blood | Y <input checked="" type="radio"/> N |
| Recent Treatment | Y <input checked="" type="radio"/> N | Use Needles | Y <input checked="" type="radio"/> N |
| Contagious Disease | Y <input checked="" type="radio"/> N | Pregnant/Recent Delivery | Y <input checked="" type="radio"/> N |
| Doctors Name and Address NONE | | | |
| Health Insurance NONE | | | |
| Special Diet NONE | | | |
| Prescriptions/Medications NONE | | | |
| Drug Allergies NONE AWARE OF | | | |
| Descriptions INMATE APPEARS FINE AT TIME OF INTAKE | | | |

I have read the above carefully and have answered all questions correctly to the best of my knowledge.

Inmate's Signature _____ Date: _____ Time: _____

Officers's Signature **CJ012 PORTREY, CLIFF** Date: _____ Time: _____

1745

12

1722

6

8

100

Exposed
Hepatitis C, B. Black death, HIV, AIDS - Hospital care.
Dr. Johnson Redmond

Order

Meth. locustae ^{very} *multiguttata*, Lenth &
freq. ^{all}

2-4 days range from
2 days to 4 weeks

20

005

17.4

107178

James King, Newport, Tenn.

Al Borge
C. J. Borge



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correctional officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 6-13-05 Pod/Location: 18 Cell: 140 ID# _____

Inmate's Full Name: Al S. Boyett

Complaint/Problem: Ear infection

How long have you had this problem? 6-12-05

Inmate's Signature: Al S. Boyett Date: 6-13-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 97.3 Resp 18 Pulse 71 B/P 114/67

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

Go to infirmary right now. Bill Case
Noted ear was pulled up in exam -
(100%) ① Unresponsive to 20
5-10 drops BID x 4 days
② of oral antibiotic to be

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
☐ Follow-Up Required? If checked, date to be seen again _____
☐ Chronic Condition
☒ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6-13-05 Seen by: [Signature]

Place original form in patient's medical record.

6-13-05 Return to Infirmary. Re-examine in 4 days.



INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correction officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay schedule at this facility.

Today's Date: 6-17-05 Pod/Location: B-Block Cell: B-1 ID# _____

Inmate's Full Name: Al Rayntt

Complaint/Problem: My ear popped and is throbbing
and I need to see the doctor
immediately

How long have you had this problem? Since Tuesday of 6-14-05
is when it started.

Inmate's Signature: Al Rayntt Date: 6-17-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 96.8 Resp 20 Pulse 78 B/P 106/64

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

Refer to M.D.
Both ears impacted wax - fear not yet removed
Thu frequency 800mg - 7 Po BID x 7 days
Leg cramps (No change P up visit)
Overhead pain

☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order

☐ Follow-Up Required? If checked, date to be seen again _____

☐ Chronic Condition

☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 6/18/05 Seen by: P. Lyman

Place original form in patient's medical record.

PHYSICAL EXAMINATION REPORT

| Examination | Findings | Diagnosis | Recommendations |
|-------------------|---|---------------------------|------------------------|
| General | Weight: 100 lbs, Height: 5'7", BMI: 20.0 | | |
| Neck | Thyroid: Normal, Lymph nodes: Normal | | |
| Chest | Lungs: Clear, Heart: Normal | | |
| Abdomen | GI: Normal, Liver: Normal, Spleen: Normal | | |
| Extremities | Upper: Normal, Lower: Normal | | |
| Neurological | Muscles: Normal, Reflexes: Normal | | |
| Psychiatric | Mood: Depressed, Thought: Normal | Major Depressive Disorder | Antidepressant therapy |
| Substance Use | Alcohol: None, Drugs: None | | |
| Review of Systems | ENT: Normal, Endocrine: Normal, Hematologic: Normal, Immunologic: Normal, Integumentary: Normal, Musculoskeletal: Normal, Nervous: Normal, Respiratory: Normal, Urinary: Normal, Vascular: Normal | | |

LABORATORY TESTS

| Test | Result | Reference Range |
|-------------------------------|--------|-----------------|
| Complete Blood Count (CBC) | Normal | |
| Basic Metabolic Panel (BMP) | Normal | |
| Thyroid Function Tests (TFTs) | Normal | |
| Urine Toxicology Screen | Normal | |

MENTAL HEALTH OBSERVATIONS

| Observation | Notes |
|-------------|---|
| Appearance | Well-groomed, appropriate attire |
| Behavior | Cooperative, follows instructions |
| Thought | Goal-directed, no delusions or hallucinations |
| Mood | Depressed, anhedonia |
| Affect | Restricted, blunted |
| Insight | Partial insight into condition |
| Judgment | Good judgment |

Signature: [Signature] Date: 6/22/05
 Signature: [Signature] Date: 6/19/05



INMATE SICK CALL SLIP – MEDICAL REQUEST

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Today's Date: _____ Pod/Location: _____ Cell: _____ ID# _____

Inmate's Full Name: _____

Complaint/Problem: _____

How long have you had this problem? _____

Inmate's Signature: _____ Date: _____

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp _____ Resp _____ Pulse _____ B/P _____

Instructions/Assessment: Document your findings, Inmate's responses/actions _____

Referred to M.D.

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again _____
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: _____ Seen by: *G. Coleman*

Place original form in patient's medical record.

COVINGTON COUNTY JAIL
INMATE REQUEST/GRIEVANCE FORM

NAME _____ BLOCK _____ DATE _____

TELEPHONE CALL CUSTODY CHANGE () PERSONAL PROBLEM
SPECIAL VISIT TIME SHEET () OTHER () GRIEVANCE

BRIEFLY OUTLINE YOUR REQUEST/ GRIEVANCE. THEN PRESENT TO C/O

REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO:

SHERIFF CHIEF JAILER () JAILER () RECORDS OFFICE () CHAPLAN

GRIEVANCE STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF APPLICABLE.

DO NOT WRITE BELOW THIS LINE - FOR REPLY ONLY:

APPROVED () DENIED () PAY PHONE () COLLECT () OTHER

SOUTHERN RADIOLOGY SERVICES, LLC
X-RAY REPORT

| | | | |
|--------------------|-----------|---------------------------|----|
| DATE | LAST NAME | FIRST NAME | MI |
| 8/16/2005 | BOYETTE | AL | |
| D.O.B. | SEX | FACILITY | |
| 1/15/1965 | M | SEB-CONVICTON COUNTY JAIL | |
| ORDERING PHYSICIAN | | X-RAY NO. | |
| MCWATLER | | | |

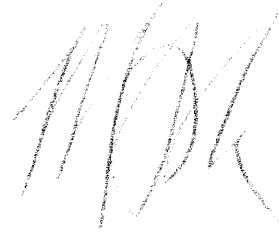
IMAGES OF THE LEFT HAND, 8/16/05

HISTORY: Edema.

Patient had trauma the week prior. Patient sustained a fracture to the neck of the fifth metacarpal without gross displacement. There is no dislocation noted either. No additional acute fracture is identified. There is a prominent spur at the distal end of the fifth digit proximal phalanx that could be related to the old trauma. No acute foreign bodies suggested.

IMPRESSION: Nondisplaced fracture of the distal fifth metacarpal.

 Vincent Martin, MD/Enc



(t) 8/16/2005 12:18:12 PM

(n) 8/16/2005 12:37:50 PM

PROGRESS NOTES

Bayati, R.

11/10/05

Notes Should Be Signed by Physician

1/29/05 S - Ankle is C/O has very little
+ leg cramps 10 5/15 7/15 1/15

2 exam - of hand of hand TM's

A. Chronic Sinusitis
leg cramps

R. Omeprazole 20mg \times 7 tabs B1
Lid

D. Dexamethasone 5K \times 7 tabs B1
Refill \times 2

Gibson, Inc.
1/29/05

1/11/05

3/17/05 S - C/O fracture of C hand
+ HPC

Southern Health Partners, Inc

ADMISSION DATA / HISTORY AND PHYSICAL FORM

Entry Date: 8/2/05 S.S.#: 4116 47 1511 ID# _____
 Inmate Name: Pugh, H. AI Date Booked: 8/2/05
 Alias: 0 Address: 14966 Hogart Rd Andover MA 01820 County: MA
 Telephone: 332 5452 Birthdate: 1/15/65 Religion: Baptist
 Education Completed: 7th Special Education: _____
 Marital Status: M W D Separated Read/Write English: YES NO Other _____
 Previous Incarcerations: (Facility/Date) 2005

MEDICAL HISTORY

Notify in Emergency: Vonnie NK Port Yonderly
 Address: 14966 Hogart Rd Andover MA 01820 Phone: 332 5452
 Health Insurance: 0
 Family Physician: Dr. Yuse, Yuse Andover MA 01820
 Past Hospitalizations (include surgeries): 0

Head Injury with Loss of Consciousness: 0 Last Tetanus: 2003 Immunization: _____
 Allergies: 0
 Current Medication(s): 0

MENTAL HEALTH EVALUATION

Hospitalization for Mental Health Reasons: YES NO If Yes, Why: Mental breakdown
 Where: Deerfield Hospital AI When: March 2004
 Psychotropic Meds (Specify type and last dose): 0
 Prior Counseling/Out-Patient Treatment for: Mental Health 1987
 Where: Andover AI 30020 When: _____
 Have you ever attempted suicide: No How: _____ When: _____
 Have you recently considered committing suicide? No
 Do people consider you a violent person? No
 Have you ever been arrested for a violent crime/sexual offense? (Specify) No
 Street drugs: None 0 100 0 Smoker: 0 Fish: 0
 Inmate's Signature: _____ Date: _____
 Interviewer's Signature: W. Pugh Jr. Date: 8/2/05
 Witness (if physical is refused): W. Pugh Jr. Date: 8/2/05

MEDICAL HISTORY & PHYSICAL ASSESSMENT

| Problems | Yes | No | Problems | Yes | No | Problems | Yes | No |
|--------------------|-----|----|-------------------|-----|----|------------------------------------|-----|----|
| Vision | | | Hypertension | | | Gonorrhea | | |
| Hearing | | | Anemia | | | Syphilis | | |
| Balanced/Blindness | | | Blood | | | Muscle Problem | | |
| Blackouts | | | Stomach Pain | | | Joint Problem | | |
| DTs | | | Heartburn | | | Arthritis | | |
| Headaches | | | Ulcer | | | Other | | |
| Seizures | | | Nausea/Vomiting | | | Other | | |
| Nervous Disorder | | | Gall Bladder | | | Regular Menstrual Period | | |
| Throat | | | Liver | | | Irregular Menstrual Period | | |
| Tooth | | | Hepatitis | | | # of days between menstrual period | | |
| Asthma | | | Diabetes | | | LMP | | |
| Hay Fever | | | Kidney Disease | | | Gravida/Para | | |
| Pneumonia | | | Bladder Infection | | | Last Pap | | |
| Tuberculosis | | | Trouble Voiding | | | Contraception | | |
| Heart | | | Pediculi (lice) | | | Other | | |

EXAM:

Age 28 Sex F Race W Ht 5'7" Wt 145

| Pulse | | | BP | | | Temp | | | Resp. | | |
|--|---|-----------------------------------|---|---|-----------|--|---|-----------|--|---|-----------|
| Area/Type | N | A/Comment | Area/Type | N | A/Comment | Area/Type | N | A/Comment | Area/Type | N | A/Comment |
| Skull: Color Condition Turgor Recent Inj. | | Torticollis, no trauma, no injury | Chest (Breasts): Configuration Auscultation Respirations Cough/Sputum | | | Heart: Auscultation Radial pulses Apical pulse Rhythm | | | Extremities: Pulses Edema Joints | | |
| Head: Glasses Pupils Sclera Conjunctiva Vision | | | Abdomen: Shape | | | Palpation: Hernia Bowel Sounds | | | Spine | | |
| Ears: Appearance Canals Hearing | | | Genital/Urinary System | | | | | | | | |
| Mouth: Teeth/Gums Dentures Plaque Throat Tongue Tonsils | | | | | | | | | | | |
| Neck: Veins Mobility Thyroid Trachea Lymph | | | | | | | | | | | |

LABORATORY TESTS

| | Date & Initial | Results |
|----------------------------------|----------------|---------|
| Was PPD planted and read timely? | 4/24/05 | 7.1 x 9 |
| VOBL / AFP | 1/3 | |
| Other Lab Tests needed | 1/3 | |
| Pregnancy Test? | | |

MENTAL HEALTH OBSERVATION

| | N | A/Comment |
|---|---|-----------|
| Orientation (person, place, time) | | |
| General appearance (order, behavior, manners) | | |
| Affect (mood) | | |
| Content of thought, history of suicide, present thoughts of suicide | | None |

Physician Examined & Signature:


Date: 5/25/05

Physician's Signature:





INMATE SICK CALL SLIP – MEDICAL REQUEST

TO BE COMPLETED BY INMATE: Please complete the top half of the Sick Call Slip and return it to the correction officer and/or medical staff for submission and review by the medical staff. The medical staff will arrange for you to be seen by the appropriate medical staff member. You will be charged in accordance with the medical co-pay system at this facility.

Today's Date: 9-3-05 Pod/Location: E 3 Cell: 108 ID# 108

Inmate's Full Name: Mr. [illegible]

Complaint/Problem: Headache, dizziness, nausea, vomiting, and abdominal pain.

How long have you had this problem? Since this morning.

Inmate's Signature: [Signature] Date: 9-3-05

TO BE COMPLETED BY MEDICAL STAFF:

Note Patient's Vital Signs: Temp 98.8 Resp 16 Pulse 64 B/P 108/70

Instructions/Assessment: Document your findings, Inmate's responses/actions

Inmate - On arrival in East Area 1st floor & Emergency, patient
complained of dizziness, nausea, vomiting, and abdominal pain.
He is on R. Kidney & Diabetes. He is on 3x44.

- ☐ Received Orders – thru Treatment Protocols; via telephone order; via verbal order
- ☐ Follow-Up Required? If checked, date to be seen again 10/10/05
- ☐ Chronic Condition
- ☐ Inmate to be charged through medical co-pay for this visit

Date Seen by Medical: 9/3/05 Seen by: [Signature]

17 1-9-01 P.H. R.H. Rep. 1270
S - Has Rep. C.

U - Has but results not coming
+ Rep. C.

A - Has Rep. C.

D - May see his own AD for
at his own expense

W. H. H. H.
9/1/01

W. H. H. H.



DEPARTMENT OF
CORRECTIONS
INMATE SICK CALL SLIP - MEDICAL REQUEST

INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE. Please complete the top half of the slip. If you are unable to complete the slip, please call the medical unit. The medical unit will assign a nurse to your wing/unit to assist you. You will be charged a co-payment for the services provided.

Wing/Room 10-7-05 Population 10-7-05

Inmate Name Al. Tamm

Complaint/Problem I have a bad cold over since then

How long have you had this problem? A week or more

Inmate's Signature Al. Tamm Date 10-7-05

TO BE COMPLETED BY MEDICAL STAFF

Med. Problem/Vital Signs: Temp _____ Resp 13 pulse 94 BP 110/70

Examination/Assessment: Document your findings, inmate's response/instructions

Wing 10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

10-7-05 Inmate Name Al. Tamm

~~Doctor~~ **SICK CALL
REFUSAL FORM**

I, H. Boyett (inmate name) understand
that my name is on the sick call list to be seen by Southern Health
Partners medical staff at Covington County Jail, and that I am
declining to be seen at this time. I further understand that it will
be documented as such in my medical file, and that my name will
NOT be added back to sick call, unless I submit another sick call
request.

H. Boyett
Inmate Signature

11/23/05
Date/Time

[Signature]
Witness Signature

11/23/05
Date/Time

Nurse Signature

Date/Time Noted

COVINGTON COUNTY JAIL
INMATE REQUEST/GRIEVANCE FORM

NAME Mr. [illegible] BLOCK 101 DATE 11/21/05

TELEPHONE CALL ☐ CUSTODY CHANGE ☐ PERSONAL PROBLEM ☐

SPECIAL ☐ TIME SHEET ☐ (☒) OTHER (☐) GRIEVANCE

IF REFUSING TO SIGN OUR REQUEST/GRIEVANCE, THEN PRESENT TO CIO

IF REQUEST PLEASE CHECK TO WHOM IT IS DIRECTED TO

SHERIFF ☐ CHIEF JAILER (☐) JAILER (☐) RECORDS OFFICE ☐ CHAIRMAN

IF GRIEVANCE, STATE PARTIES INVOLVED AND NAMES OF WITNESSES IF AVAILABLE.

Mr. [illegible]
Would you please get an appointment for me to see
Dr. [illegible] for HIV as I may have some medical problem
that will require medical attention.

11/21/05
inmate requesting Hep-C profile to determine
if he has it. Dz [illegible]

[Signature]

APPROVED THIS LINE - FOR REPLY ONLY:

APPROVED ☐ DENIED ☐ PAY PHONE ☐ COLLECT ☐ OTHER ☐



INMATE SICK CALL SLIP - MEDICAL REQUEST

TO BE COMPLETED BY INMATE - Fill in details to the best of your ability. If you are unable to fill out this form, please ask the medical staff for assistance. The information provided must be true and accurate. If you provide false information, you may be subject to disciplinary action.

Today's Date: 11/23/05 Registration # 111111 Cr. # 1111

Inmate Full Name: John Doe

Current Problem: I have a sore on my leg and back

and I have a sore on my back and leg

and I have a sore on my back and leg

How long have you had this problem? Over a week

Physician Signature: Dr. Smith Date: 11/23/05

TO BE COMPLETED BY MEDICAL STAFF:

Physician's Vital Signs: Temp 100.0 Resp 20 BP 120/80

Physical Assessment: Document your findings. Inmate's name: John Doe

On back has abrasion on his leg and buttocks

Abdomen has bruise on his left side

Diagnosis: Injury, Bruise, Abrasion, Pain, Discomfort

Recommendation: Pain relief, Wound care, Hydration



Physician Orders - (for Treatment Provider use only)

All required. Inmate to be seen again

Physician

Physician Signature: Dr. Smith

Date: 11/23/05 X Smith

MEDICATION ADMINISTRATION RECORD

| MEDICATIONS | HOURS | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | 11 | 12 |
|---|----------------------------|---|---|---|---|---|---|---|---|---|----|----|----|---|---|---|---|---|---|---|---|---|----|----|----|
| Zinc 150 mg T BID | Am Omeprazole pm Pseudo | | | | | | | | | | | | | | | | | | | | | | | | |
| Metoprolol 50 mg T BID + 10 days | Am Omeprazole pm Pseudo | | | | | | | | | | | | | | | | | | | | | | | | |
| Vecuronium BR + Cap BID + 30 days (Refill 12) | Am Omeprazole pm Pseudo | | | | | | | | | | | | | | | | | | | | | | | | |
| Enalapril 20 mg BID + 10 days | Am Omeprazole pm Pseudo | | | | | | | | | | | | | | | | | | | | | | | | |

STARTING FOR 7/1/05 THROUGH 7/31/05

Physician: [Signature] Telephone: _____

Nurse: [Signature] Telephone: _____

Pharmacy: [Signature] Telephone: _____

Medication Number: 416-08-1511

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